Editorial: Playing With Lives
Philadelphia Inquirer
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June 23, 2009
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Problems at the Philadelphia VA Medical Center surrounding the mistreatment of dozens of veterans with prostate cancer should have been exposed as far back as 2002 - when red flags first arose.

But it took until mid-2008 to raise the alarm, at which point federal officials finally launched an investigation into claims that patients' radiation doses were inadequate or excessive, or that some implanted radiation seeds simply missed the mark.

This is far from the minimum standard of care when it comes to battling this form of cancer through so-called brachytherapy. Not only that, some botched surgeries resulted in other organ damage that required further operations. So the delay in detecting the problem treatment took a toll in unnecessary suffering by the vets, as well as running up taxpayers' tab for Veterans Affairs medical care.

Now it's up to the federal officials at the VA and other agencies to figure out why, and to order tougher patient-safety procedures. South Jersey congressman John Adler has rightly called for hearings to determine what went wrong.

No matter what puts veterans in a VA hospital, they deserve far greater assurances that there's a fail-safe system in place to detect medical errors of any type.

The veterans with prostate cancer certainly expected that, but investigators say the Philadelphia VA didn't have basic procedures to detect radiation errors. Even worse, a New York Times account Sunday reported that some of the errors were covered up.

Is that a thundering herd of plaintiff's attorneys on the move? Indeed, the botched treatments highlight the larger problem of limiting preventable errors at all hospitals, especially as the health-care industry looks to reduce costs and expensive lawsuits.

At least, brachytherapy treatments at the Philadelphia VA were suspended last year as the probe was launched. According to details that emerged in recent days, 92 cases were mismanaged and most of the surgeries were performed by a University of Pennsylvania radiation oncologist, Gary D. Kao.
Kao, who stopped seeing patients last year but continues research at Penn, was among a group of Penn specialists the VA contracted to launch its prostate radiation program.

A key issue for the Nuclear Regulatory Commission - which regulates these treatments - is

whether VA outsourcing contributed to the lack of peer review and oversight at its hospital.

Had the errors occurred at Penn, for example, they likely would have been reported under the state's patient-safety act, and triggered steps designed to prevent a recurrence.

For their part, VA hospital officials have shown they're attuned to preventing more common errors, such as patients being sickened by hospital-borne infections.

The hope is that the botched prostate cancer treatments represent a troubling aberration.